TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Sentry Casualty Company

MFDR Tracking Number
M4-16-0728-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This medication does not require preauthorization according to Rule 134.530 & 134.540."

Amount in Dispute: $495.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "2 bills were submitted on the same exact date resulting in one being rejected as a duplicate The first bill paid correctly, in full.

On the duplicate billing, it doesn't match the billed amount because the provider billed a total amount less than what the total should have been based on the charges for each ingredient. If you add the charges for all ingredients the total is $498.15.

It appears the total on the provider's bill was not correct."

Response Submitted by: Sentry Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 15, 2015	Prescription Medication (Compound)	$495.44	$495.44

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the guidelines for billing and reimbursing pharmaceutical services.

3. 28 Texas Administrative Code §134.530 sets out the requirements for use of the closed formulary for claims not subject to certified networks.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent. Rx Number 6506655 reduced $495.44
   - W3 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 18 – Duplicate Claim / Service Rx Number 6507525 reduced $498.15 Previous Paid on 08/07/2015; Check# 570129.

Issues

1. Did the insurance carrier reimburse the disputed services?
2. Is the insurance carrier's reason for denial of payment supported?
3. What is the total reimbursement for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier indicated in their position statement that they reimbursed the disputed services in full and provided an Explanation of Benefits dated July 30, 2015 to support this. Review of the submitted documentation finds that the dispute involves a compound medication with the following ingredients:

   - Flurbiprofen, 6.0 units
   - Meloxicam, 0.18 units
   - Mefenamic Acid, 1.8 units
   - Baclofen, 3.0 units

   The Explanation of Benefits provided by the insurance carrier demonstrates reimbursement of a compound medication with the following ingredients:

   - Meloxicam, 0.18 units
   - Flurbiprofen, 4.80 units
   - Tramadol HCl, 6.00 units
   - Cyclobenzaprine HCl, 1.80 units
   - Bupivacaine HCl, 1.20 units

   The Division finds that the insurance carrier has not reimbursed the services in dispute.

2. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Precertification/ authorization/notification absent." 28 Texas Administrative Code §134.530(b)(1) states that preauthorization is only required for:

   (A) drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates;
   (B) any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; and
   (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

   The Division finds that Flurbiprofen, Meloxicam, Mrenamic Acid, and Baclofen are included in the closed formulary and have a status of "Y" in the edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary* effective on the date of service. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. The total reimbursement for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503 (c), which states, in relevant part:

    (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
    (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
    (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount…
    (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
    (A) health care provider

    The requestor is seeking reimbursement for a compound of the generic drugs Flurbiprofen, NDC 38779036209; Meloxicam, NDC 38779274601; Mefenamic Acid, NDC 38779066906; and Baclofen, NDC 38779038809. The disputed medication was dispensed on June 15, 2015. The reimbursement is calculated as follows:

Date of Service	Prescription Drug	Calculation per §134.503 (c)(1)	§134.503 (c)(2)	Lesser of §134.503 (c)(1) & (2)	Carrier Paid	Balance Due
6/15/15	Flurbiprofen	(35.5800 x 6.0 x 1.25) + $4.00 = $278.35	$210.90	$210.90	$0.00	$210.90
6/15/15	Meloxicam	(194.6700 x 0.18 x 1.25) + $4.00 = $47.80	$35.04	$35.04	$0.00	$35.04
6/15/15	Mefenamic Acid	(123.6000 x 1.8 x 1.25) + $4.00 = $282.10	$146.90	$146.90	$0.00	$146.90
6/15/15	Baclofen	(35.6300 x 3.0 x 1.25) + $4.00 = $137.61	$102.60	$102.60	$0.00	$102.60

4. The total reimbursement amount for the disputed service is $495.44. The insurance carrier paid $0.00. An additional reimbursement of $495.44 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $495.44.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $495.44 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	December 4, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.